Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island

Office of the Health Insurance Commissioner
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OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Protecting Consumers Ensuring Solvency Engaging Providers Improving the System

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I. Executive Summary

Under Rhode Island Statute, the Office of the Health Insurance Commissioner (OHIC) is responsible for enforcing statutes regarding commercial health insurers in the state. An analysis of commercial insurers' payments to hospitals in 2008 was conducted to assess the existence of any payment variation by health plan or hospital and to assess the effects of any variation on two statutory standards for Commercial Insurer conduct: fair treatment of providers, and efforts to promote health insurance affordability. Findings from this analysis are summarized below.

General Characteristics of Hospital Payments

This report analyzes average hospital inpatient payments from the two major health plans. It focuses specifically on the eleven acute care hospitals in Rhode Island – excluding Bradley, Butler, The Rehabilitation Hospital of Rhode Island, and Eleanor Slater Hospital (a public long term care hospital).

- The average split of hospital payments from the two insurers was 76 percent from BCBSRI and 24 percent from UHCNE and roughly reflected their enrollment and premium shares in the RI commercial insurance market.
- Overall, casemix-adjusted average rates of reimbursement to the eleven acute care hospitals for medical and surgical services varied by less than five percent between the two health plans.
- The vast majority (76 percent) of the payments were made to the five acute care hospitals affiliated with either the Lifespan Corporation (46 percent) or Care New England Health System (30 percent), while only 24 percent of the payments went to the remaining six unaffiliated community hospitals.
- There was a wide variation in inpatient vs. outpatient revenue from the two health plans, ranging from 30 percent inpatient and 70 percent outpatient revenue for Westerly Hospital, to 56 percent inpatient and 44 percent outpatient revenue at Rhode Island Hospital. The average across all hospitals was evenly split at 50 percent inpatient and 50 percent outpatient revenue.

Variations in payment among the Eleven Acute Care Hospitals in Rhode Island

Variations in commercial inpatient medical-surgical payment rates (75 percent of all inpatient payments) were combined for both insurers and analyzed for each hospital. Four measures were used to compare payment from the plans to the hospitals: payment per diem, payment per stay, case mix-adjusted payment per stay, and payment per stay relative to what Medicare would pay. Because no measure is perfect, emphasis is placed on findings that are robust across all measures.

- The average payment per stay, adjusted for casemix, was about 116 percent of what Medicare would have paid for the same set of patients. Medicare payment levels form a common benchmark in payment negotiations nationwide, since Medicare payment levels are public knowledge and are intended to approximate the cost of care. Nationally, as in Rhode Island, private-sector insurers usually pay somewhat more than Medicare.[1]

[1] Medicare Payment Advisory Commission, Medicare Payment Policy, Report to Congress (Washington, DC: MedPAC, pp57-64; American Hospital Association, Trendwatch Chartbook 2009 (Chicago:AHA, 2009), Chart 4.6.

- However, variation in average case mix adjusted inpatient rates of reimbursement between hospitals was significant, ranging from 79 percent of Medicare's comparable payment (at Roger Williams) to 167 percent (at Kent).
- Hospitals affiliated with either of the two systems in Rhode Island are compensated on a case mix adjusted basis at 149 percent of Medicare for Care New England hospitals and 117 percent of Medicare for Lifespan hospitals. In comparison, unaffiliated hospitals are paid at an average of 97 percent of Medicare.

These findings are summarized in the following table:

	Lifespan	CNE	Unaffiliated	Average
Per Diem Payments	$3,696	$3,266	$2,397	$3,238
Payment Per Stay	$14,586	$12,164	$9,437	$12,687
Average Casemix adjusted payment per stay indexed to overall average,	1.08	1,19	.75	1.00
Casemix adjusted payment per stay as a percent of Medicare payment	117%	149%	97%	116%

For outpatient care, precise analyses could not be conducted. Inter-hospital differences for outpatient payments appeared narrower than for inpatient payments. They also appear to parallel, rather than compensate for, inpatient variations.

Hypotheses for higher commercial insurers payments to system-affiliated hospitals include greater leverage possessed by these systems in contract negotiations, greater burdens of teaching care, higher levels of uncompensated care and cost-shifting to commercials insurers resulting from Medicare and Medicaid underpayments. There is no evidence that system-affiliated hospitals have relatively higher unreimbursed uncompensated care or teaching costs than unaffiliated hospitals, and the three highest-paid hospitals have unremarkable Medicaid and Medicare volumes. There is considerable evidence that the hospital systems - particularly Care New England - possess power in particular service markets that gives them negotiating leverage.

The overall effect of any variation on "fair treatment of providers"

The public policy affirming the private negotiation of payments between insurers and hospitals for commercially insured populations has resulted in wide variations in payments to hospitals on a case mix-adjusted basis and compared to Medicare. As a result, hospitals affiliated with systems are paid more for similar services than un-affiliated hospitals. They are also paid more relative to Medicare, which attempts

to adjust for the costs of teaching and uncompensated care. This outcome can be deemed as fair only if Medicare's method of payment is assessed as unfair.

Eliminating any variation in commercial inpatient medical surgical payments would shift up to 15 million dollars in commercial inpatient medical-surgical payments between hospitals in a given year. The most substantial adjustments would be for Kent (a 44 percent reduction) and Roger Williams (a 32 percent increase). No assessment could be done for outpatient payment.

The overall effect of any variation on health insurance affordability in the state

The effects of this variation in payment levels on the affordability of health insurance depends on an assessment of what is determined to be a fair level of reimbursement. If all hospitals were to accept the lowest rate of inpatient payment currently accepted by any hospital, it would reduce hospital inpatient payments by 48 percent, which could reduce commercial insurance premiums by up to 3.9 percent. Alternatively, paying hospitals at the highest level negotiated would increase hospital inpatient payments by 30 percent, which could increase needed premiums by up to 5 percent. No analysis was possible for outpatient payments.

No reliable national comparisons to the estimate of 116 percent of Medicare that insurers pay in Rhode Island could be found. Figures quoted nationally range up to 140% of Medicare, so it may be safe to conclude that on average hospitals in RI are not relatively overpaid for inpatient services.

Any effort to address the apparent relative underpayment of unaffiliated hospitals in RI that simply raised their payment levels would raise overall payment levels and thus adversely affect health insurance affordability. Such efforts would also best be coupled with expectations for reforming not only how much hospitals are paid but how they are paid, to address concerns about the inherently inflationary aspects of the current fee for service payment system which dominates both Medicare and commercial hospital payment mechanisms.

II. Introduction

As part of their administrative efforts, health insurers negotiate contracts with providers on behalf of insurance customers. The terms of these contracts include units of service and rates of pay, and are considered proprietary information. These terms have direct effects on the affordability and quality of health insurance and medical care services used by insurance customers. This practice of assembling and privately negotiating for suppliers' services on behalf of a customer in exchange for an aggregate price is consistent with many other industries. However, the process of private negotiations conducted by medical providers and insurers is at odds with the method that public purchasers use for obtaining the same services. Medicare uses standardized, publicly accessible price schedules, which are subject to public discussion, analysis and adjustment. In April 2010, the Rhode Island fee-for-service Medicaid program plans to implement a similar payment method with price schedules posted on the Internet.

Under Rhode Island Statute, the Office of the Health Insurance Commissioner (OHIC) is responsible for enforcing statutes regarding commercial health insurers in the state. Its activities include guarding the solvency of health insurers in RI; protecting the interests of consumers; encouraging fair treatment of providers; encouraging policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and encouraging and directing insurers toward policies that advance the welfare of the public through efficiency, quality improvement and appropriate access. [2]

Annual health insurance premium rates for both large employer groups and small employer groups in Rhode Island require OHIC approval. To inform this annual review, OHIC collects and reviews the major rate factors used by health insurers to develop their proposed premium rates. In conjunction with its review of rate factors[3] for 2009, OHIC collected and reviewed confidential hospital and other provider payment data from Blue Cross & Blue Shield of Rhode Island (BCBSRI) and United Healthcare of New England (UHCNE).[4] This report provides summary analyses, utilizing this data submission.

The purpose of this report is to understand what variations exist in per patient payments by commercial insurers to hospitals as a result of the private contracting process. This is important to understand for two reasons central to OHIC's statutory responsibility:

1. OHIC is responsible for holding health plans in RI accountable for fair treatment of providers.[5] To the extent that variations in provider payments exist for like services, this could constitute unfair treatment.
2. OHIC is responsible for holding health plans in RI responsible for their statutory obligation to improve the affordability of RI's health system. [6] Payments to hospitals comprise approximately 40

[2] RIGL 42-14.5-2
[3] Annual health insurance premium rates for both large employer groups and small employer groups in Rhode Island require the Office of the Health Insurance Commissioner (OHIC) approval. To inform this annual review, OHIC collects and reviews the major factors used by health insurers to develop their proposed premium rates. These factors, collectively called "rate factors", include: medical cost inflation trends, contributions to reserves/profits, and administrative costs. The first factor, medical cost inflation trends, consists of estimated inflation rates of price and utilization for each of five medical service categories. These categories are: hospital inpatient services, hospital outpatient services; pharmacy, primary care and other medical.
[4] Although Tufts submitted rate factors, as a new market entrant they did not have hospital payment data to analyze.
[5] RIGL 42-14.5-2
[6] Office of the Health Insurance Commissioner Regulation 2: Powers and Duties of the Office of the Health Insurance Commissioner

percent of health insurance premiums. Variations in hospital payment rates may affect the affordability of health insurance in RI.

The hospital payment analysis in this report draws on analysis done by ACS Government Healthcare Solutions as a consultant to OHIC. The data set was provided by the two insurers, and included payments for inpatient and outpatient services to RI's eleven acute care hospitals, two psychiatric hospitals, and one rehabilitation hospital affiliated with an acute care hospital. The data set included CY 2008 services paid through March 2009 and excluded pending claims. The data set did not include payment information for Medicare, Medicaid Fee for Service, Medicaid Managed Care (RIte Care), other commercial insurers, or individual policies. ACS organized the data and conducted a simulation of Medicare payment; the findings and discussion in this report are those of OHIC. [7]

III. Source Data and Summary Findings by Hospital

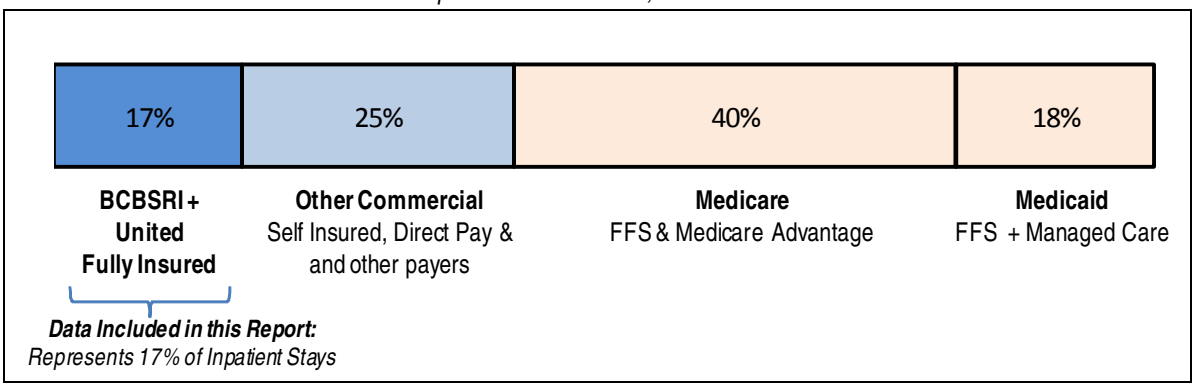
The dataset included a total of $321 million in payments to Rhode Island hospitals by insurers for both inpatient and outpatient services. Payments to the state operated long term care hospital – Eleanor Slater Hospital – were not included in the dataset.

The dataset included only those payments for small/large group policy-holders with risk-based contracts with BCBSRI and UHCNE. As shown in Figure 1, fully insured commercial business is only seventeen percent of the inpatient volume of Rhode Island's hospitals. However, although self insured and individual insurance payments are not included in this analysis, the rates of payment used by commercial insurers for these two lines of business – based on representations to OHIC - are thought to be similar in most cases to those for self- insured employer contracts and the payment policies being analyzed here could effect of 42% of the inpatient volume at Rhode Island hospitals..

[7] The Office of the Health Insurance Commissioner gratefully acknowledges the work of Kevin Quinn and Connie Courts of ACS, Cara Sammartino, Emory University Public Health Intern, and several reviewers in producing this report. The analysis offered here is from OHIC.

Figure 1: Source of Inpatient Stays[8]

Hospitals in Rhode Island, Calendar Year 2008



Analysis of payment variation focused specifically on the eleven acute care hospitals, excluding Bradley, Butler, and The Rehab Hospital of Rhode Island[9]. Table 1 is a summary of payments by plan and by service location for the eleven acute care hospitals in the dataset analyzed for this report.[10] As shown below, payments to the eleven acute care hospitals totaled $310.3 million, which was evenly split between inpatient and outpatient services.

Table 1: Total Payments in Dataset Analyzed

Commercial Payments by BCBSRI and UHCNE to RI's Acute Care Hospitals

(Full-risk Employer Contracts Only: Excludes Self-insured Commercial and Individual Contracts)

Calendar Year 2008

Dollar figures in millions / figures may not add exactly due to rounding

	Rhode Island	Miriam	Kent County	St. Joseph	Women & Infants	Roger Williams	South County	Memorial	Newport	Westerly	Landmark	Total
Inpatient Payments												
BC/BS	$39.2	$16.5	$12.7	$4.9	$25.5	$5.3	$5.0	$3.2	$3.4	$2.1	$2.0	$119.7
United	$11.3	$5.1	$5.0	$1.7	$6.9	$1.6	$0.7	$1.0	$1.0	$0.4	$0.6	$35.3
Total	**$50.5**	**$21.6**	**$17.7**	**$6.6**	**$32.4**	**$6.9**	**$5.6**	**$4.1**	**$4.3**	**$2.5**	**$2.7**	**$155.0**
Outpatient Payments												
BC/BS	$30.5	$14.6	$11.2	$7.0	$18.7	$5.6	$7.4	$6.3	$5.8	$4.7	$3.2	$115.0
United	$9.2	$5.3	$5.0	$2.9	$7.2	$1.9	$1.8	$1.7	$2.8	$1.0	$1.4	$40.3
Total	**$39.7**	**$19.9**	**$16.1**	**$10.0**	**$25.9**	**$7.5**	**$9.2**	**$8.1**	**$8.6**	**$5.7**	**$4.6**	**$155.3**
Total Inpatient and Outpatient Payments												
BC/BS	$69.7	$31.1	$23.9	$12.0	$44.1	$11.0	$12.4	$9.5	$9.1	$6.7	$5.2	$234.7
United	$20.5	$10.5	$9.9	$4.6	$14.2	$3.4	$2.5	$2.7	$3.8	$1.4	$2.0	$75.6
Total	**$90.2**	**$41.6**	**$33.9**	**$16.6**	**$58.3**	**$14.4**	**$14.8**	**$12.2**	**$12.9**	**$8.1**	**$7.3**	**$310.3**

Health plan enrollment data submitted to OHIC indicates that fully insured commercial enrollment constitutes 59% of total plan commercial self- or fully insured. If utilization and hospital payment methodology for self-insured products are consistent with fully insured business, than the $310 million in hospital payments depicted in table one are representative of $525 million in total payments to hospitals by BCBSRI and United for commercial enrollees.

[8] Source: RI Department of Health IP Data, CY 2008, OHIC reported carrier market share data, OHIC analysis

[9] Bradley and Butler are both specialized, private psychiatric hospitals.

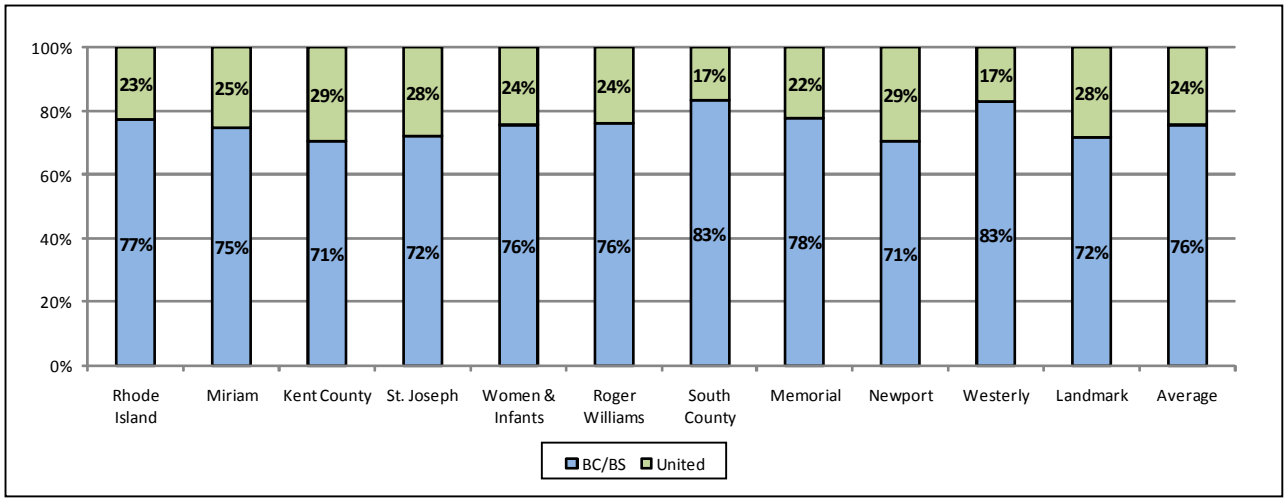
[10] Table 1 does not include payments to Bradley and Butler Hospitals, nor to Rehab Hospital of RI

At OHIC's request, health plans submitted hospital inpatient payment data by MS-DRG (regardless of whether the payment was made on a DRG basis)[11]. This provided the basis for comparison of payments on an acuity-adjusted basis, which allows for an "apples to apples" comparison of payment levels between hospitals. This also provided the basis for the comparison of health plan payments to what Medicare Fee for Service would have paid for the same service.

A comparison of the relative amount paid to each acute care hospital by each health plan, for inpatient and outpatient services combined, provides a perspective on the relative hospital revenue from BCBSRI, the dominant health plan in RI, vs. UHCNE for each hospital (see Figure 2). Payer splits range from 83 percent BCBSRI payments vs. 17 percent UHCNE payments at South County and Westerly Hospitals to a split of 71 percent BCBSRI payments vs. 29 percent UHCNE payments at Kent and Newport Hospitals. The average split of hospital revenue from the two insurers is 76 percent from BCBSRI and 24 percent from UHCNE and roughly reflects their enrollment and premium shares in the RI commercial insurance market. Differences between hospitals in this regard may reflect employers' choice of health plan in a hospital's primary service area.

Figure 2: Percent of Hospital Revenue from BCBSRI vs. UHCNE

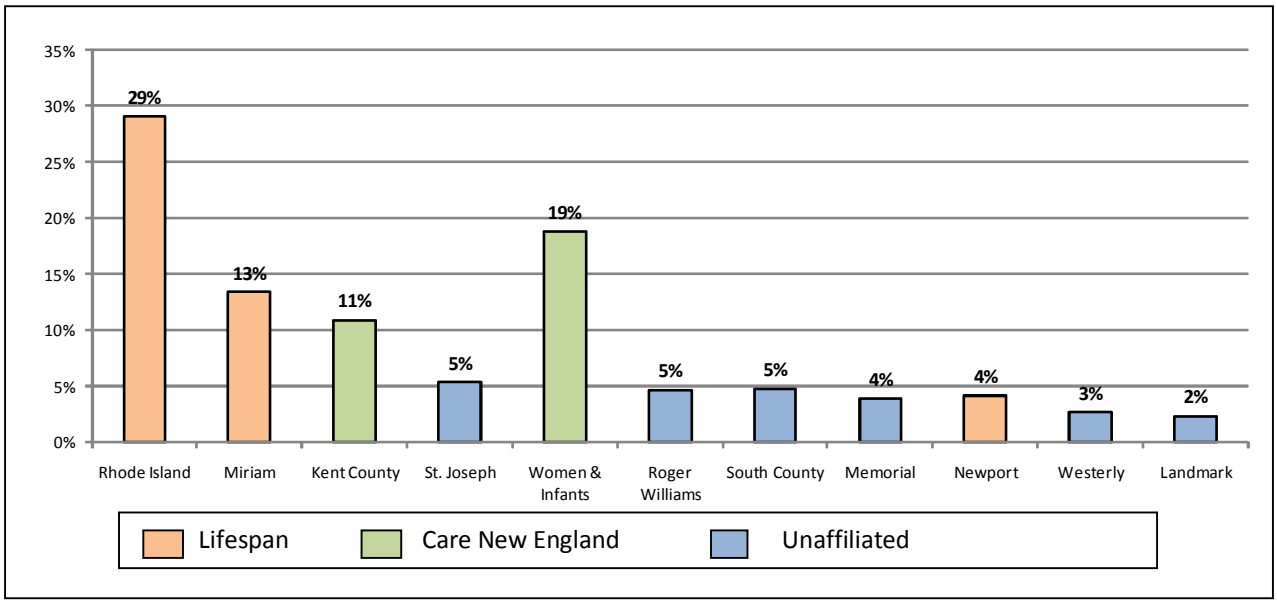
Acute Care Hospitals in Rhode Island, Calendar Year 2008



As shown in Figure 3, of the combined inpatient and outpatient payments reported by the two health plans, 29 percent of these payments were made to RI Hospital; two percent of these payments were made to Landmark Hospital; and the other nine acute care hospitals making up the rest fell within this range.

[11] DRG – or Diagnosis Related Groups – is used by Medicare as a way of categorizing diseases and procedures into units of service provided by hospitals. This permits standardized payments and analysis. MS-DRG refers to a subsequent refinement of the same categorization.

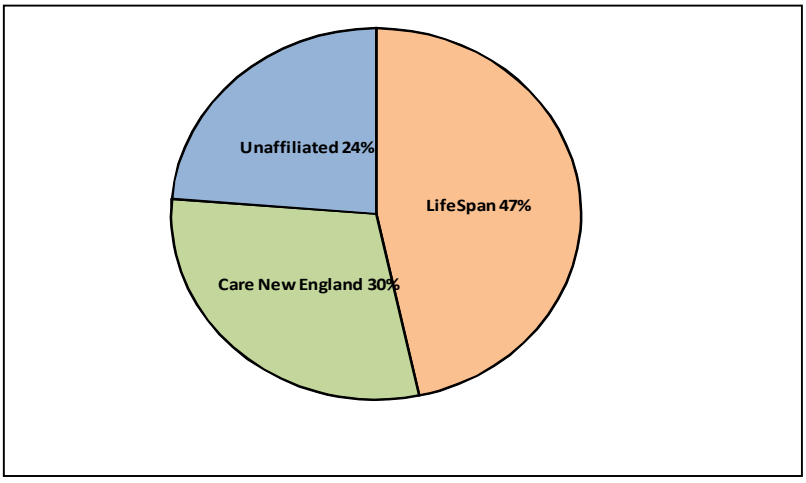
Figure 3: Percent of Total Health Plan Payments by Hospital
Acute Care Hospitals in Rhode Island, Calendar Year 2008



Rhode Island has two large hospital systems. Lifespan is the largest system, comprising Rhode Island Hospital, The Miriam Hospital, Newport Hospital, and Bradley Hospital. Care New England is composed of Women and Infants Hospital, Kent County Memorial Hospital and Butler Hospital. Unaffiliated hospitals are community hospitals which are not part of the Lifespan Corporation or Care New England hospital systems and that were not affiliated with each other in 2008 or 2009. Six hospitals meet this criterion: Roger Williams Hospital, St. Joseph Hospital (who plan to affiliate with each other beginning in 2010), South County Hospital, Memorial Hospital, Landmark Medical Center, and Westerly Hospital.

Figure 4 shows the share of payments by each hospital system and for unaffiliated hospitals. The vast majority (76 percent) of the payments were made to the 5 acute care hospitals affiliated with either the Lifespan Corporation (47 percent) or Care New England Health System. (30 percent), while only 24 percent of the payments went to the remaining 6 unaffiliated community hospitals.

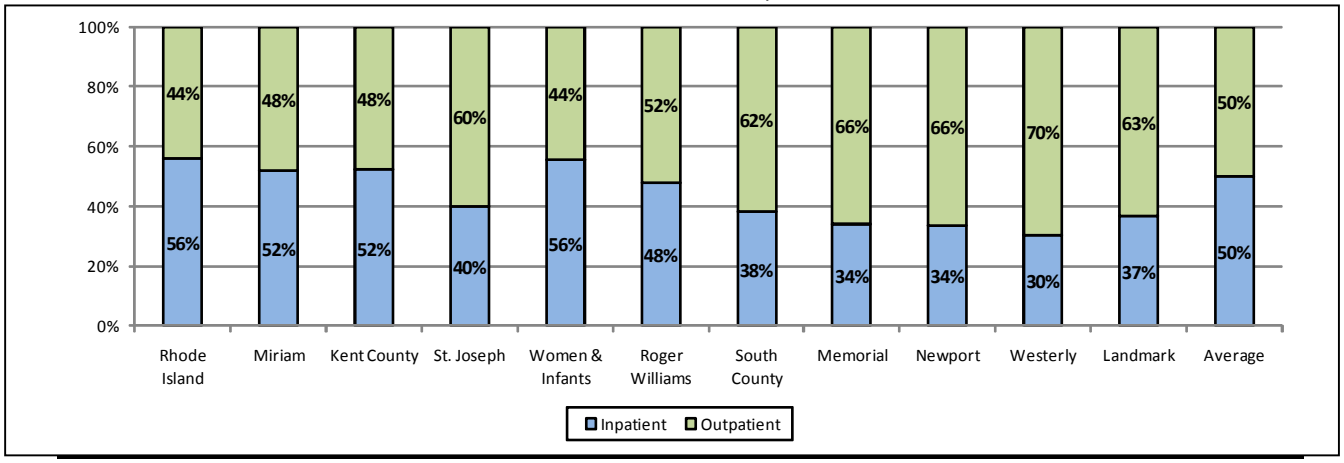
Figure 4: Percent of Total Health Plan Payments by Hospital System
Acute Care Hospitals in Rhode Island, Calendar Year 2008



A comparison between hospitals shows a wide variation in inpatient vs. outpatient payments from the two health plans, ranging from 30 percent inpatient payments and 70 percent outpatient payments for Westerly Hospital, to 56 percent inpatient payments and 44 percent outpatient payments at Rhode Island and Women & Infants hospitals (Figure 5). The average across all hospitals was an even split at 50 percent inpatient payments and 50 percent outpatient payments.

Figure 5: Percent Inpatient vs. Outpatient Payments by Hospital

BCBSRI and UHCNE Combined, Acute Care Hospitals in RI, Calendar Year 2008



IV. Variation in Inpatient Medical/Surgical Service Payments among Health Insurers to the Eleven Acute Care Hospitals in RI

A detailed quantitative analysis was conducted to measure the extent of variation in health plan inpatient payments from the two health plans. This analysis included payments to the eleven acute care hospitals in Rhode Island. It was limited to medical/surgical services, which comprise 75 percent of inpatient payments to acute care hospitals, and excluded behavioral health and obstetrics admissions. A summary of the data used for this analysis is provided in Table 2.

Table 2: Summary of Hospital Payments Included in the Dataset

Total Hospital Payments in Dataset	$321 Million
Payments to the Eleven Acute Care Hospitals	$310 Million
Inpatient Payments to Acute Care Hospitals	$155 Million
Inpatient Payments to Acute Care Hospitals for Medical Surgical Services	**$117 Million**

Comparisons of payment rates for behavioral health admissions were not included because comparable health plan payment data were not available. Comparisons of payment rates for obstetrical admissions

were also not included because variation in payment methodologies across insurers made comparisons to medical surgical categories and between health plans difficult.[12]

Average hospital payment rates for BCBSRI were compared to average hospital payment rates for UHCNE, across all hospitals combined, adjusted for case-mix. On average across all inpatient hospital payments, the two health plans pay about the same for inpatient hospital stays. Case mix-adjusted inpatient payments, on average across all hospitals, differed by less than five percent between the two insurers studied[13]. Because the analysis found that inter-hospital variation was significantly greater than the inter-plan variation, the remainder of this report will focus on average differences in payments to hospitals.

To compare payment rates from the plans to the hospitals, four measures were used. No measure is perfect, but if all measures tend to tell the same story this increases the confidence in the robustness of the findings. The measures are: payment per diem, payment per stay, case mix-adjusted payment per stay, and payment compared with what Medicare would have paid for the same set of stays.[14] In principle, case-mix adjusted payment is the most appropriate measure, but all measures are described so that readers can draw their own inferences.

A. Per Diem Payment

Payment per diem is the simplest comparison. This measure implicitly assumes that all hospital days are similar and consume similar amounts of resources, when in fact there are substantial differences among patients in the care they need per day. Further analysis is then needed to determine if any differences found between hospitals are compensated for by efficiency differences, or if they may be due to differences in patient severity.

Figure 6 shows significant variation in payment per diem, from $1,888 per day to $4,012 per day. In general, payment per day is higher for larger urban hospitals, and lower for community hospitals. As shown in Figure 7, payment per diem to the system hospitals – Lifespan and Care New England – is a third higher than to unaffiliated community hospitals.

[12] Obstetric payments and Outpatient payments are discussed separately in Section V.
[13] A detailed analysis was performed, comparing inpatient payment rates for medical surgical services by health plan.
[14] A fifth possible measure would be payment compared with hospital charges. However, charges have become almost meaningless as a measure of hospital resources. On average in Rhode Island, hospital charges are about two and a half times higher than hospital costs. See American Hospital Association, AHA Hospital Statistics, 2009 Edition (Chicago: AHA, 2009), p. 129. Hospitals vary significantly in how aggressively they mark up charges over cost, so comparison of pay-to-charge ratios is of limited validity when making comparisons between hospitals.

Figure 6: Average Med/surg Payment per Inpatient Day ("Per Diem")
BCBSRI and UHCNE Fully Insured Hospital Payments, CY 2008

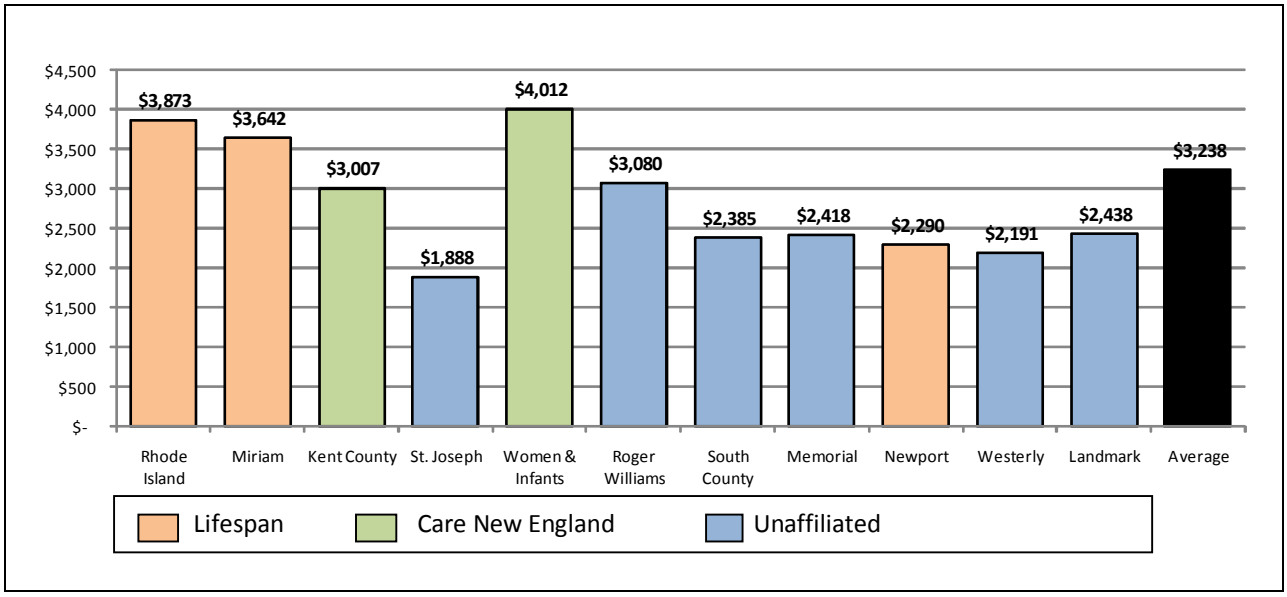
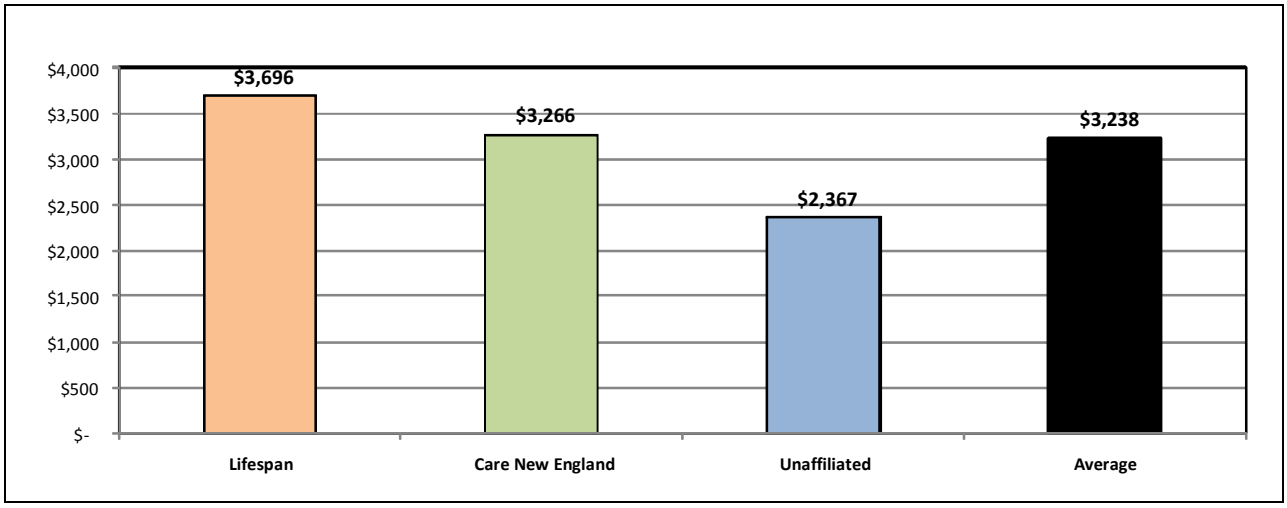


Figure 7 Average Med/Surg Payment per Inpatient Day ("Per Diem") by Hospital Affiliation
BCBSRI and UHCNE Fully Insured Hospital Payments, CY 2008



B. Payment per Stay

Payment per stay is a more sophisticated measure than payment per diem. The hospital stay is the clinically meaningful unit of payment. Payment per stay captures both the average length of stay and the implicit payment per diem. Analyzing payments on a per stay basis thus adjusts for relative hospital efficiency but does not consider the complexity of a hospital's patient population.

Figure 8 again shows significant variation, from $7,730 per stay at Westerly Hospital to $15,378 at Rhode Island Hospital – almost a doubling. As was true with payment per diem, payment per stay to the system

hospitals – Lifespan and Care New England – is about a third higher than to the unaffiliated community hospitals.

Figure 8:Average Payment per Inpatient Med/Surg Stay
BCBSRI and UHCNE Fully Insured Hospital Payments, CY 2008

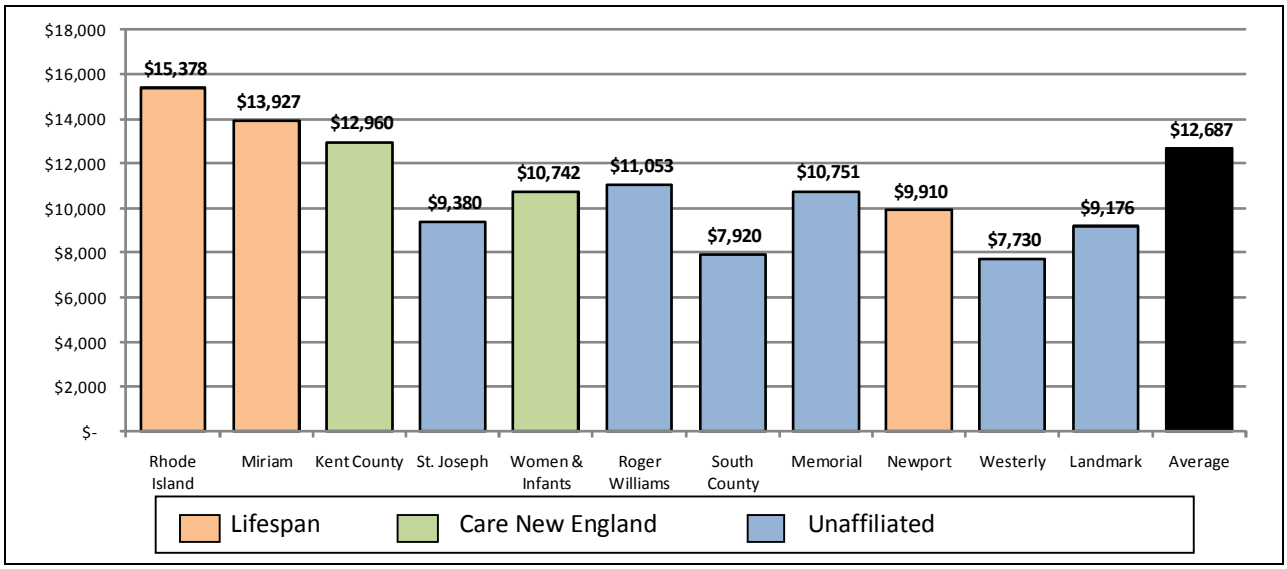
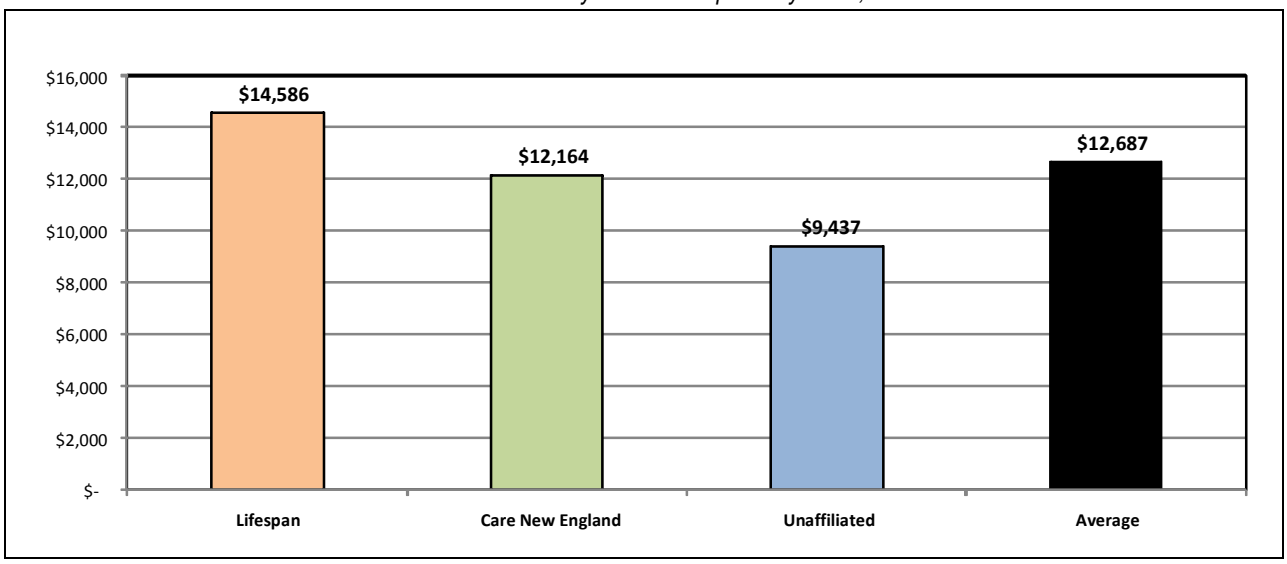


Figure 9: Average Payment per Inpatient Med/Surg Stay by Hospital Affiliation
BCBSRI and UHCNE Fully Insured Hospital Payments, CY 2008



C. Case-mix Adjusted Payment per Stay

Case-mix adjusted payment per stay is, in principle, the most appropriate measure because it adjusts for the significant differences in case mix across hospitals. Validity of the comparison depends heavily on the validity of the case mix measure itself. For this analysis, BCBSRI and United were asked to submit data by Medicare Severity Diagnosis Related Group (MS-DRG), regardless of whether they used MS-DRGs in calculating payment. MS-DRGs are the most commonly used measure of hospital case mix

nationwide. For example, MS-DRGs differentiate between simple pneumonia, pneumonia with a complication, and pneumonia with a major complication. Although MS-DRGs are not suitable for all types of patients (especially newborns and obstetrics) they are very appropriate for the medical-surgical patients described in this analysis.[15]

In Figure 10, every hospital would be at 100 percent if each received the same payment on a case mix-adjusted basis. Instead, we see the same pattern as in Figures 7 and 9, where the system hospitals tend to receive higher payment than the unaffiliated hospitals. However, the relative rankings change. Kent County Hospital is paid 20 percent higher than the average across all the hospitals while South County Hospital is paid 35 percent less than the average across all hospital analyzed.

Figure 10: Case Mix Adjusted Inpatient Med/Surg Payments, Indexed to Average Payment per Inpatient Stay
BCBSRI and UHCNE Fully Insured Hospital Payments, CY 2008

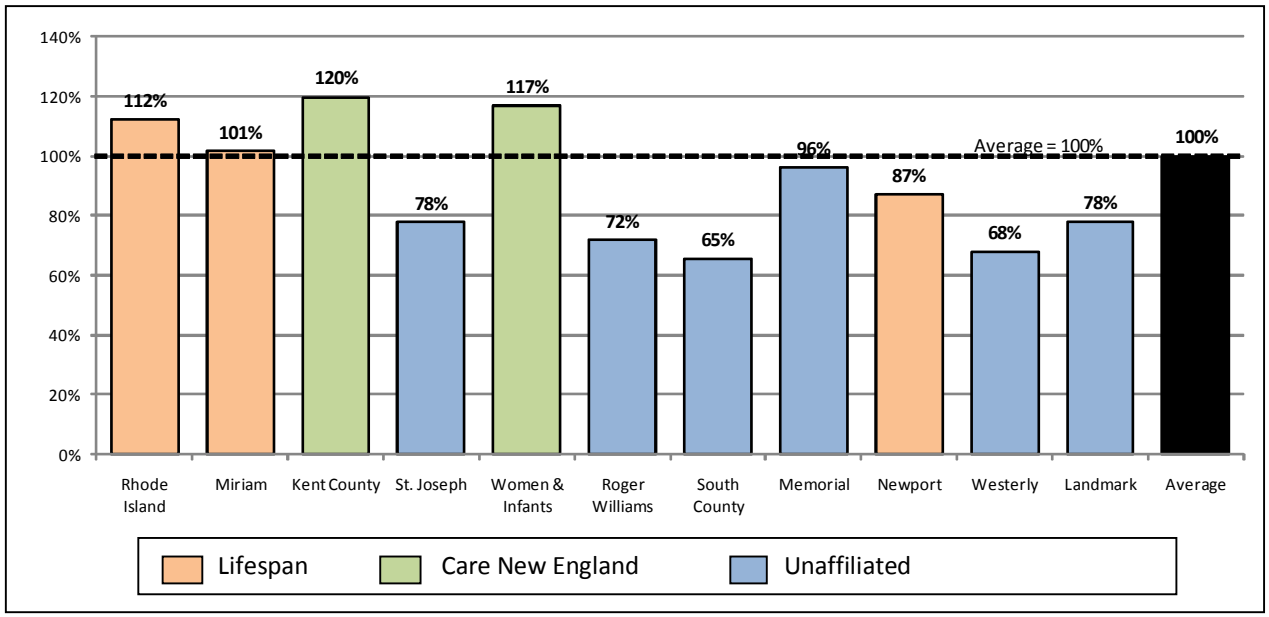


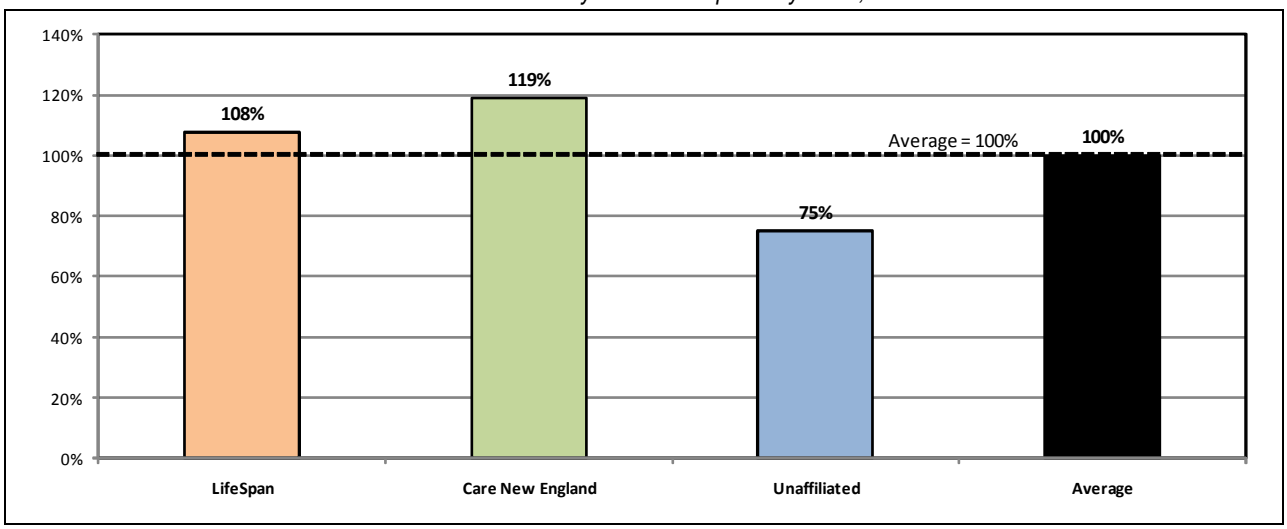
Figure 11 groups hospitals by affiliation status. When case mix is accounted for, Care New England hospitals appear to be the highest compensated group for equivalent inpatient services, replacing Lifespan (see Figure 9 for analysis without case mix adjustment). In addition, the case-mix adjusted per stay equivalent payment rate for system hospitals – Lifespan and Care New England – is 47 percent higher than the per stay equivalent payment rate for unaffiliated community hospitals.

There could be other reasons for payment variation beyond case mix, which this analysis does not capture. Hypotheses include higher base costs due to teaching responsibilities or levels of uncompensated care, contracting strategies and leverage, and differing levels of performance quality or outcomes.

[15] Barbara O. Wynn, Megan K. Beckett, Lee H. Hilborne et al., Evaluation of Severity-Adjusted DRG Systems, Addendum to the Interim Report to the Centers for Medicare and Medicaid Services (Santa Monica, CA: RAND, July 2007).

Figure 11: Case Mix Adjusted Inpatient Med/Surg Payments, Indexed to Average Payment per Inpatient Stay by Hospital Affiliation

BCBSRI and UHCNE Fully Insured Hospital Payments, CY 2008



D. **Payment Compared with Medicare**

As the dominant payer for hospital services nationwide, Medicare is often considered a benchmark in analyzing hospital payment rates. Medicare rates are sufficient to cover 96 percent of the average cost of caring for Medicare inpatients nationwide [16] For this measure, the consultants to OHIC (ACS Government Healthcare Solutions) repriced each inpatient stay in the analytical dataset using Medicare payment principles. The most important component is the Medicare base payment, which comprises the MS-DRG relative weight times the Medicare DRG base price (called the standard amount)[17]. Because MS-DRGs are used in calculating Medicare payment, this comparison is automatically adjusted for case mix.

Figure 12 shows that, on average, the plans paid hospitals approximately 116 percent of what Medicare would have paid for the same set of patients[18]. As did earlier figures, Figure 12 also shows that the system hospitals tend to be paid a higher percentage of the Medicare benchmark than the unaffiliated hospitals.

It is important to note that as the dominant hospital payer, Medicare does not negotiate payment levels like its commercial counterparts - it sets them, based on an assessment of allowable costs, including

[16] Medicare Payment Advisory Commission, Medicare Payment Policy, Report to Congress (Washington, DC: MedPAC, March 2009), p. 56.

[17] Although there is only one wage area defined for Rhode Island by Medicare, some Rhode Island hospitals have successfully asked Medicare to use Massachusetts or Connecticut wage areas in calculating the DRG base price for their hospitals. The Medicare payment estimates used in this analysis reflect the RI, MA or CT wage areas applicable to each hospital, based on information from the CMS web site.

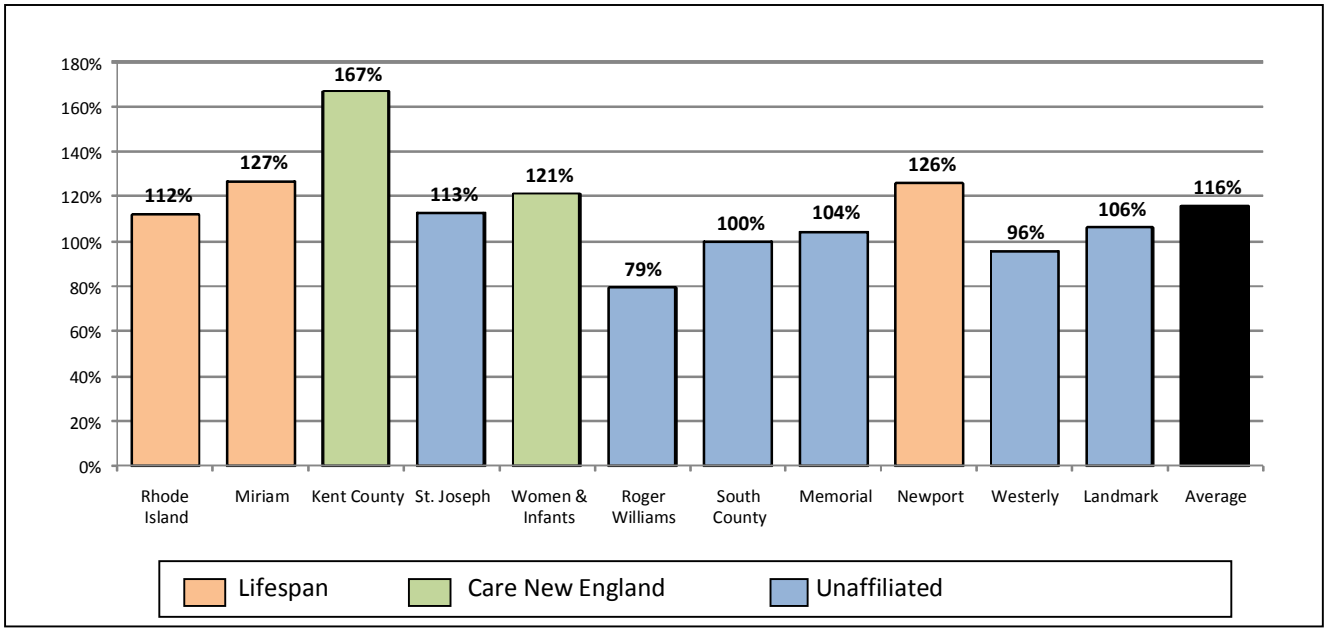
[18] Calculation of the Medicare payment should be considered approximate. This calculation also included other hospital-specific components, such as payment for capital and indirect medical education. Outlier payments were approximated as 5% of DRG payments; since the consultants did not have claim-specific data, it was not possible for them to calculate actual outlier payments. Medicare payment for direct medical education was omitted from the analysis due to lack of specific information. For the state's teaching hospitals, Medicare payments are therefore slightly understated and the ratio of commercial payments to Medicare payments are slightly overstated.

appropriate differences attributable to case mix, uncompensated care, teaching and local costs of living. Medicare calculations represent a common benchmark and payment methodology, and provide a working definition of "fair payment" to the extent a public process is deemed to produce a fair outcome.[19]

Medicare also represents a national standard or benchmark for payment levels. This addresses a weakness of the case mix adjusted methodology employed in the previous section, which is useful for comparing hospitals to one another but offers only an assessment of relative differences between hospital payments.

Significant variation was found between the hospitals in case mix-adjusted payments per stay indexed to Medicare. In fact, commercial payments to hospitals bear little similarity to Medicare payment levels (Figure 12). Kent County Memorial Hospital had the highest payment relative to Medicare; the hospital's average case mix-adjusted payment equivalent per stay was 67 percent higher than what Medicare would have paid. Roger Williams and Westerly Hospital payments were lower than the Medicare equivalent payment. Figure 12 also demonstrates that the four hospitals with the highest case mix-adjusted payment relative to Medicare were hospitals affiliated with either Lifespan or Care New England.

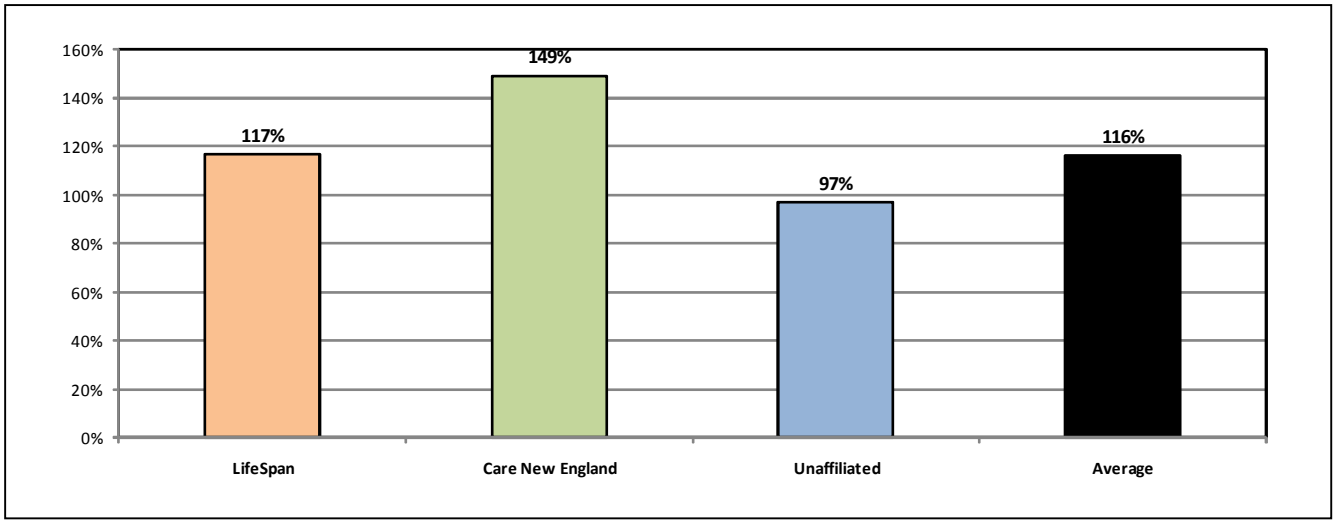
Figure 12: CMI-Adjusted Inpatient Med/Surg Payments, Indexed to Percent of Medicare Fee for Service
BCBSRI and UHCNE Fully Insured Hospital Payments, CY 2008



[19] There is considerable controversy over what constitutes allowable costs and whether Medicare's method of calculating them is fair and accurate. To the extent a hospital considers the process to be neither fair nor accurate and to the extent a hospital has economic leverage, the private negotiating process with commercial payers represents an opportunity to recoup expenses not reimbursed by Medicare and additional payments for other purposes. This mixed model of hospital payment – where public payers determine appropriate and allowable costs and set rates and commercial payers negotiate them on behalf of private purchasers creates a confusing set of incentives and opportunities for cost shifting by both hospitals and payers.

Figure 13 presents the same information aggregated by hospital system membership. Compared to Figure 11, adding Medicare payment as a benchmark emphasizes the relative overpayment of Care New England by commercial insurers relative to levels Medicare considers appropriate.

Figure 13: CMI-Adjusted Inpatient Med/Surg Payments
Indexed to Percent of Medicare Fee for Service by Hospital System
BCBSRI and UHCNE Fully Insured Hospital Payments, CY 2008



Hospitals are forced by statute to serve all patients, regardless of ability to pay. Some hospitals assume additional programs for training physicians. Both of these responsibilities can create additional cost burdens, which, as has been noted, Medicare attempts to calculate in a hospital-specific fashion and pay for. While the Medicare reimbursements attempt to pay for its share of costs associated with these responsibilities, not all costs, the fact that commercial payments exceed these levels would indicate that commercial insurers are paying for at least their share of these costs, as calculated by Medicare.

V. Effect of Excluded Services on this Analysis

As noted previously, three major service areas were excluded from this analysis: inpatient behavioral health, inpatient obstetrics and all outpatient services. To what extent does their exclusion affect this analysis and can any more general observations be drawn from the data submitted by the plans?

A. Behavioral Health Admissions

These represent seven percent of all inpatient payments in the data set (as compared to 72 percent for medical/surgical services) and are concentrated at Bradley (part of the Lifespan System) and Butler (a Care New England member) hospitals[20]. In Rhode Island, United Healthcare "carves out" behavioral health care to another unit of the parent company; the carve-out data were not included in the data set submitted to OHIC for this analysis. Therefore no analysis was done of payments for these services.

B. Obstetrics and Newborn Admissions

These represent 20 percent of all inpatient payments. Seventy to eighty percent of all cases analyzed were at Women and Infants. As indicated previously, variations in billing units used by hospitals and insurers, possible grouper limitations and lack of a comparable Medicare payment all make conclusions difficult. Some analysis was done with the following findings:

- Greater variations in payment between plans - on a per diem and per case basis - exist for obstetrics and for newborn care than for medical/surgical services.

- On average, both obstetrics and newborn services at Women and Infants are reimbursed about 50% higher per stay than at the average of other hospitals. The plans pay substantially higher rates for obstetrical care to Women and Infants Hospital than to the other hospitals with obstetrics and delivery services, regardless of whether rates are measured on per diem, per stay without casemix adjustment, or per stay with casemix adjustment.

However, because of incomplete coding and possible limitations in the MS-DRG, case mix adjustment for obstetrics and newborns could not be conducted. This makes comparisons very limited, since Women and Infants has the only level one Neonatal Intensive Care Unit in the region and thus attracts all severe cases which in turn raises its costs per stay.

C. Outpatient Services

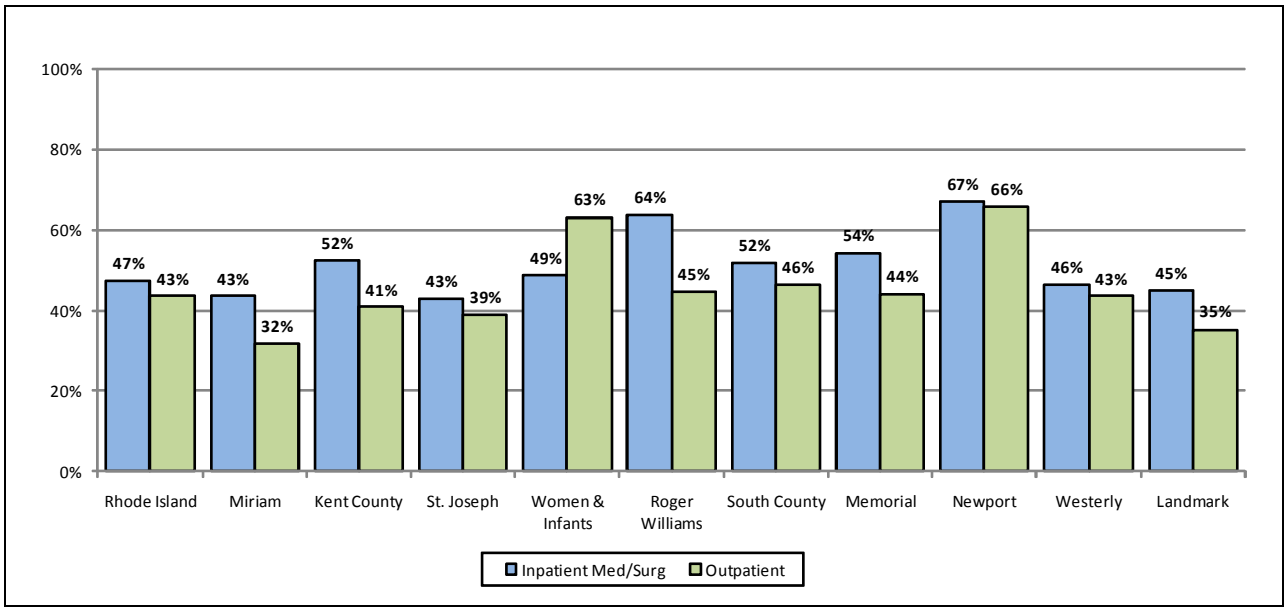
The outpatient payment data obtained by OHIC, shown in Table 1, summarizes outpatient payments by plan and hospital and shows that outpatient services now constitute 50 percent of payments to hospitals from commercial insurers on average. Thus, payments for outpatient services have a significant impact on both hospital revenue and on the cost of health insurance. Unlike for inpatient services, hospitals and insurers use a wide variety of payment methods and specific service definitions for outpatient services. As a result, the outpatient payment data provided by insurers is much less standardized than the inpatient

[20] Medical-surgical payments represent 72 percent of inpatient payments in the dataset, which includes Bradley, Butler and the Rehab Hospital of Rhode Island. Medical-surgical payments represent 75 percent of all inpatient payments to the eleven acute care hospitals analyzed, as shown in Table 2.

payment data. Due to this limitation in the outpatient data, it was not possible to create credible payment comparisons of outpatient payments by Health Plans to each of the hospitals using this data set.

However, analyses that could be generated for outpatient payments were comparisons between inpatient and outpatient payments for each hospital based on percentage of charges. This comparison is provided below in Figure 14.

Figure 14: Comparison of Outpatient and Inpatient Payment Levels by BCBSRI and UHCNE Combined
Measured as Payment as Percent of Hospital Charge, CY 2008



There are significant drawbacks of this method of analysis in making comparisons across hospitals because the method for calculating charges is not standardized across plans, there is no adjustment for patient severity (although this is less of a concern for outpatient services) and there is no ready comparison to a Medicare payment and its definition of allowable costs.

However, the outpatient data is useful in determining how well a particular hospital is paid for outpatient services relative to that same hospital's payment for inpatient services. Figure 14 shows the relative similarity in level of payment for inpatient and outpatient services relative to hospital charge for each hospital. This is an indication that outpatient payments do not appear to compensate for the variations in inpatient payment levels.

Inter-hospital differences for outpatient payments appear narrower than for inpatient payments. This may reflect greater price competition for outpatient services from non-hospital providers.

VI. Effect of the Variability in Hospital Payment Rates on the Affordability of Health Insurance

Calculations were made to estimate the effects of this variability on payments to providers and total health plan expenses (see Table 3). It can be argued that differentiated payments to hospitals that by analysis appear to be correlated only with system membership is "unfair". Table 3 estimates the redistribution in inpatient payments if there were no variability between hospitals and all were paid at the same levels. It then looks at the effect of those levels on the affordability of health insurance.

Table 3 indicates that eliminating any variation in commercial inpatient medical surgical payments would shift $9 million dollars in commercial inpatient medical-surgical payments between hospitals in a given year. If this dataset is representative of all commercial payments, it would shift up to $15 million between hospitals.[21] The most substantial adjustments would be for Kent (a 44 percent reduction) and Roger Williams (a 32 percent increase).

Table 3: Inpatient Payment Analysis
Commercial Payments by BCBSRI and UHCNE to RI's Acute Care Hospitals - Calendar Year 2008
(Full-risk Employer Contracts Only: Excludes Self-insured Commercial and Individual Contracts)
Dollar figures in millions[22]

	Rhode Island	Miriam	Kent County	St. Joseph	Women & Infants	Roger Williams	South County	Memorial	Newport	Westerly	Landmark	**Total**
Inpatient Payments												
BC/BS	$39.2	$16.5	$12.7	$4.9	$25.5	$5.3	$5.0	$3.2	$3.4	$2.1	$2.0	$119.7
United	$11.3	$5.1	$5.0	$1.7	$6.9	$1.6	$0.7	$1.0	$1.0	$0.4	$0.6	$35.3
Total	**$50.5**	**$21.6**	**$17.7**	**$6.6**	**$32.4**	**$6.9**	**$5.6**	**$4.1**	**$4.3**	**$2.5**	**$2.7**	**$155.0**
% of Medicare	**112%**	**127%**	**167%**	**113%**	**121%**	**79%**	**100%**	**104%**	**126%**	**96%**	**106%**	**116%**
Total IP payments if all paid at average (116% of Medicare)												
Total	$52.3	$19.8	$12.3	$6.8	$31.0	$10.0	$6.5	$4.6	$4.0	$3.0	$2.9	$153.3
Difference	$1.8	-$1.8	-$5.4	$0.2	-$1.4	$3.2	$0.9	$0.5	-$0.4	$0.5	$0.2	-$1.7
% Change	*3%*	*-9%*	*-44%*	*3%*	*-5%*	*32%*	*14%*	*10%*	*-9%*	*17%*	*8%*	*-1%*
Total IP payments if paid at lowest % of Medicare (RWMC - 79%)												
Total	$35.8	$13.6	$8.4	$4.7	$21.2	$6.9	$4.5	$3.2	$2.7	$2.1	$2.0	$105.0
Difference	-$14.7	-$8.1	-$9.3	-$2.0	-$11.2	$0.0	-$1.2	-$1.0	-$1.6	-$0.4	-$0.7	-$50.0
% Change	*-41%*	*-59%*	*-110%*	*-42%*	*-53%*	*0%*	*-26%*	*-32%*	*-59%*	*-21%*	*-34%*	*-48%*
Total IP payments if paid at highest % of Medicare (Kent - 167%)												
Total	$75.1	$28.4	$17.7	$9.8	$44.5	$14.4	$9.4	$6.6	$5.7	$4.3	$4.2	$220.3
Difference	$24.6	$6.8	$0.0	$3.2	$12.1	$7.5	$3.8	$2.5	$1.4	$1.8	$1.5	$65.3
% Change	*33%*	*24%*	*0%*	*32%*	*27%*	*52%*	*40%*	*37%*	*24%*	*43%*	*36%*	*30%*

Table 3 also indicates that if the two health plans studied paid all hospitals at the lowest average negotiated rate (79 percent of Medicare) for inpatient services, they would spend $50 million dollars less than they did, or about 3.9 percent of total premium.[23] Again assuming that the dataset analyzed is

[21] As noted previously, we estimate that the commercial fully insured dataset analyzed is likely representative of all commercial payments, including the self insured and individual markets. Data reported by carriers to OHIC indicates that risk contracts (fully insured) account for approximately 59 percent of total enrollment.

[22] Differences in totals due to rounding.

[23] Based on 2008 commercial premiums of $1.3 billion (Annual carrier financial filings submitted to OHIC).

representative of all commercial payments, they would spend up to $84 million less.[24] Correspondingly, paying at the most expensive average negotiated rate (167 percent of Medicare) would increase expenses by $65 million, or 5 percent of premium.

This analysis does not include outpatient payments, which are equal to the size of inpatient payments. If outpatient payment rates by hospital showed similar patterns of variability, then fair treatment of provider concerns as represented above would be exacerbated and similar additive savings and expenses could be expected for health insurance premiums. [25]

This analysis should not be construed as indicating that setting commercial inpatient rates is appropriate policy or that a level of 79 percent of Medicare is financially sustainable for hospitals. In preparing this report, no credible national comparisons to the Commercial to Medicare payment ratio in Rhode Island could be located. [26] If found, such a figure could provide an external reference point for assessing whether the commercial inpatient medical/surgical rates in RI are relatively affordable or not. In the absence of that, the MedPac analysis that in 2008 Medicare inpatient payments amounted to 96% of hospitals' costs[27] remains the most credible standard.

[24] As noted previously, we estimate that the commercial fully insured dataset analyzed is likely representative of all commercial payments, including the self insured and individual markets. Data reported by carriers to OHIC indicates that risk contracts (fully insured) account for approximately 59 percent of total enrollment.

[25] As noted previously, conclusions on outpatient payments were far more limited: Outpatient payment variation by hospital appears to exist and parallels (rather than compensates for) inpatient payment variance. The magnitude could not be estimated.

[26] Data from MedPac and the American Hospital Association AHA may indicate a comparable figure as high as 140% but it is not apparent that the analytical methods used were consistent with those employed by ACS for this study.

[27] See footnote 16.

VII. Discussion

Adjusted for case mix, commercial inpatient medical surgical service payments to hospitals in Rhode Island vary significantly and appear to be related to system membership. The five acute care hospitals affiliated with either Care New England or Lifespan, with 76 percent of the commercial insurance business in Rhode Island, appear to be significantly better-paid than the six unaffiliated community hospitals. In addition, the hospital system with perhaps the most unique service has the highest case-adjusted payments. Care New England – with the only neo-natal intensive care services, and 70-80 percent of the obstetrical deliveries in the state - appears to be significantly better-paid than Lifespan relative to Medicare. These findings are consistent with what has previously been seen in other reports. An analysis for the Governor's Community Hospital Task Force[28] indicated in broad terms that variations in commercial payment rates existed across hospitals in Rhode Island. The *Boston Globe* investigated system membership and found a significant relationship between the total payments Boston hospitals received and whether or not that hospital was part of a system[29]. Other studies have noted similar relations between size, system membership and either payments to hospitals or their reported costs. [30]

Why might system hospitals be paid more than unaffiliated hospitals? One explanation might be that insurers' payments are subsidizing the hospitals in the provision of uncompensated care and the highly paid hospitals bear a disproportionate burden. Analysis by the Department of Health of net uncompensated care burdens (defined as uncompensated care less Medicaid and Medicare payments for uncompensated care as a percentage of total patient revenues) in 2007 did not support this hypothesis. Care New England's net uncompensated care burden of 2.12% was less than either Lifespan (3.53%) or unaffiliated hospitals (2.31%). [31]

A second explanation is that payments vary because of a "cost shift" whereby hospitals seek higher payment levels from private insurers to offset lower payment levels from Medicare and/or Medicaid. This hypothesis would imply that commercial payments are highest to hospitals where relative Medicare and Medicaid patient volumes are highest. This is not the case with the three highest paid hospitals relative to Medicare - Kent County, Miriam and Newport. Based on fiscal year 2009 charge data, these three hospitals have among the lowest Medicaid patient loads in the state and Medicare patient loads which are at the average (Kent and Newport). [32]

A third explanation is that the plans pay more to hospitals affiliated with Care New England and Lifespan because of the teaching costs borne by Rhode Island Hospital, Miriam Hospital, and Women and Infants

[28] Community Hospital Task Force (2007). Report of the Community Hospital Task Force. Available at: http://www.ohic.ri.gov/Committees_communityhosptaskforce.php
[29] Allen S, Bombardieri M. "A healthcare system badly out of balance." The Boston Globe November 16, 2008.
[30] See http://www.pioneerinstitute.org/pdf/Kane-web.pdf and "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" (Robert Wood Johnson Foundation Synthesis Project: http://www.rwjf.org/pr/product.jsp?id=15231
[31] RI Hospital Uncompensated Care (2007). Rhode Island Department of Health, 2009. (http://www.health.ri.gov/publications/financialreports/UncompensatedHospitalCare.pdf)

[32] Communication with Hospital Association of Rhode Island.

Hospital in particular. Either the insurers wish to explicitly subsidize medical education or the costs of medical education affect the negotiations with the hospitals. However, Figures 10 and 12 showed that casemix-adjusted payments were high for Kent Hospital, a Care New England hospital that does not have a teaching program, and low for Memorial Hospital and Roger Williams Medical Center, unaffiliated hospitals with significant teaching components.

Overall, it appears that the most likely reason for the differentials in commercial insurers' payments comes down to the balance of negotiating strength between the parties, as is true elsewhere in our economy. Negotiating strength for a hospital relative to an insurer presumably reflects a balance of factors such as location, number specialized services, volume of care, quality of care, hospital cost, and the number of competitors for services. Care New England provides for approximately 80% of the deliveries in the state each year and has the only neonatal intensive care unit in the state. This constitutes considerable power in a very large market (new born births).

As noted in the introduction to this report, the statute founding the Office of the Health Insurance Commissioner gives the Office two standards relevant to this analysis – the responsibility for insurers to treat providers fairly and to adopt policies that promote affordability of health insurance. These two are to be held in tension – paying all hospitals at 167 percent of Medicare rates may be fair, but probably is not affordable. How does this analysis help assess the effects in Rhode Island of the private contracting process between insurers and hospital providers on these two standards?

What is fair?

A workable definition of a fair hospital payment process is equal treatment of equal parties under equal circumstances. The focus of this definition is on the payers and whether they treat hospitals equally. This appears to be the legislative intent in the OHIC statute. The analysis in this report indicates that while health plans do not appear to be treating hospitals equally with regard to payments – as indicated by varying levels of payment for similar services – they are "equally unequal"; that is the hospitals which are paid relatively well are paid well by both health plans, apparently due to system affiliation and the resulting negotiating leverage possessed by those systems.

A second definition of fair treatment of providers in hospital payment practices could be "equal opportunity" for hospitals. In this case, the focus is less on the health plans, than the public policies that govern the payment determination process. Since the 1980s, public policy in Rhode Island and elsewhere has favored private negotiation strategies between insurers and hospitals as a way to adjudicate fairness. Advocates of such a policy would argue that the discrepancies in payment found in this analysis are simply the workings of the market, which should be allowed to continue. Such a perspective would assume that the market is rewarding higher quality and value at certain hospitals with higher prices. This study looked only at price and did not attempt to assess the value obtained for the price paid.

If there is an inequality at work in the way hospitals are paid for services in Rhode Island, it appears to be an inequality resulting from current market-based public policies where – based on this analysis - the greater the hospital market power, the higher the payment, rather than one resulting from health plan strategy. A hospital payment system for commercial insurers that relies on public payer methodologies – for instance one that pays all hospitals at the same percent of Medicare levels or a state overseen rate setting process such as exists in Maryland - might appear to treat providers more equitably than the

current policy. However, if the public payer methodology fails to capture relevant and publicly desirable differences in circumstances or outcomes between hospitals, then a fairness standard is not met.

What is affordable?

Does the 16 percent premium paid by commercial insurers relative to Medicare for inpatient medical surgical services contribute to health insurance that is relatively more affordable? Although no direct comparisons to this analysis could be found, the premium paid in aggregate by commercial insurers to hospitals compared to Medicare appears to be consistent or on the low side when compared to national averages or other states. [33]

Could a contracting process that is fairer also be more affordable? Care must be taken that in addressing any unfairness in the current hospital payment process, affordability is not worsened. Simply raising rates to unaffiliated hospitals in RI will worsen health insurance affordability.

Affordability can be set either by the free market or government oversight or subsidy. A policy contradiction exists between the federal and state government's method of determining appropriate prices for hospital services - an elaborate price setting methodology under Medicare and a similar one under Medicaid - and the private negotiation process employed by commercial insurers. The first approach treats hospital services as public goods, the government as monopsony power with quality and safety overseen by regulation. The second relies on existence of the conditions of a free and fair market to adjudicate fair prices and quality: perfect information; no participant with market power to set prices; no barriers to entry or exit; and equal access to production technology. At best these approaches are inconsistent – creating opportunities for cost shifting and inefficiencies - and at worst they are irreconcilable.

While Medicare's price is a starting point for provider-insurer negotiations, the end point is often not known – by reasons of contract law and contract terms. Is this proprietary protection of information in the public interest? Would its more frequent disclosure be inherently inflationary as the bottom half chases the top? Or will it result in public calls for alternatives to the market mechanism for adjudicating fairness and affordability?

Finally, numerous analyses point to the inherent flaws and faulty incentives in the current hospital payment methodologies, which create inherently inflationary trends.[34] This report would indicate that that health insurance affordability in Rhode Island is not threatened by the relative variations in payments for like services that exists among hospitals or in current absolute hospital payment levels. The primary threat is a payment system – perpetuated by Medicare – in which hospitals benefit when they perform more services on more people. In Rhode Island, the private contracting process has not produced these types of payment reforms. Any effort to address concerns about the fair treatment of unaffiliated hospitals or the market power possessed by current or proposed hospital systems should also increase the likelihood of meaningful hospital payment reform to improve health insurance affordability in Rhode Island.

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[33] See e.g.: http://www.bcbs.com/news/bluetvradio/cost-shift-study-2008/us-cost-shift-20081208.pdf; and http://www.haponline.org/downloads/HAP_Facts_About_Underfunding_by_Medicare_and_Medicaid_and_the_Hidden_Tax_on_Pennsylvania_Citizens_March2009.pdf;

[34] See footnote 16.

VIII. Appendix: Methods and Limitations

There are several methodological limitations to this analysis:

- There was no independent verification of the accuracy of the data submitted by the health plans to the analysts or by the hospitals to the health plans. .
- In excluding obstetrics and behavioral health, approximately 28 percent of inpatient payments are not analyzed. It is possible that a different payment pattern exists for the excluded services.
- Payments for outpatient services comprise more than half of all payments to hospitals for patients with commercial insurance. They received only a limited analysis. It is possible that a more comprehensive analysis may yield different conclusions than the directional ones offered here.
- The data are for claims paid in the period under study. It does not capture any subsequent changes in payment rates or methodologies. Thus, the highly publicized renegotiation between BCBSRI and Care New England during the fall of 2008 is not reflected in this data[35].
- The payments included only those for small/large group policyholders with risk-based contracts with BCBSRI and UHCNE. This accounts for less than 20 percent of total hospital payments. The data set did not include groups with self-insured arrangements with BCBSRI or UHCNE. Nor did it include payment information for Medicare, Medicaid Fee for Service, Medicaid Managed Care (RIte Care), other commercial insurers, or individual policies.[36] [37]
- The MS-DRG grouper was used to assess case mix severity. Although evaluated extensively, it is not a perfect tool.
- To the extent Medicare payments are used as a standard, its method of accounting for hospital costs – including uninsured care and academic training – may be incomplete or inaccurate and thus not capture appropriate and allowable variations in costs.
- The Medicare payment rate used as a standard in this report excludes payment for direct medical education due to lack of specific information. For the state's teaching hospitals, Medicare payments are therefore slightly understated and the ratio of commercial payments to Medicare payments slightly overstated.

[35] "Blue Cross, Care New England Strike Five Year Deal," Providence Journal, December 4, 2008
[36] ACS (2009). Commercial Payment for Hospital Care. Prepared for the Rhode Island Office of the Health Insurance Commissioner.
[37] Although self insured and individual insurance payments are not included in this analysis, the rates of payment used by commercial insurers for these two lines of business – based on representations to OHIC - are thought to be similar in most cases to those for commercially insured business.